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LEADING ARTICLES

SYPHILIS AS A NON-VENEREAL DISEASE.

A. H. OHMANN-DUMESNIL, A. M., M. E., M. D., LL. M., PH. D., PHIL. D., ETC.

ST. LOUIS

Professor of Dermatology in the Medical Department, Barnes University.

One of the prerequisite preliminary conditions that should be observed before entering upon the discussion of a question is an agreement upon the terms of the proposed consideration of the questions that are involved. In the present instance it is necessary that a clear understanding be had of the term venereal; for, after all, the entire matter hinges upon this. So that it is best to define this term before entering upon any prolonged discussion of the matters at issue. If we consult two of the most prominent lexicographers in matters both medical and non-medical we find that the word venereal is thus defined: In Gould's larger medical dictionary the definition of venereal is given, pertaining to the sexual passion. On the other hand, we find the following in Webster's Unabridged Dictionary: of or pertaining to venery, or sexual love; relating to sexual infections.—Med; arising from sexual intercourse; as a venereal disease. Incomplete as these definitions are they will perforce have to serve us for the nonce. Having disposed of this preliminary matter we may now permit ourselves to enter into a consideration of the subject.

To begin with it may not be inappropriate to call attention to the importance of syphilis both as a disease process and as a social factor. It is not the intention of the writer to enter into the well thrashed fields of the history of medicine in so far as its age is concerned, where it first arose or other questions which are far from having been definitely determined. These questions are still *sub judice* and the efforts of investigators to give positive answers to these are far from being completed. In fact, they are being daily nourished by finding new proofs either for or against a certain contention. We can hardly be expected to act as umpire in a question which has but an indistinct connection with the question which is about to be considered. That which is more germane to the subject is a clear view of the dissemination as well as distribution of the disease. For, by a study of this we shall be enabled to come to some conclusion regarding the question as to whether this disease is on the decrease, is increasing or is in *statu quo ante*. These conditions are perhaps more important to us, as physicians, than many would suppose at first blush. For, it must not be supposed that because our methods of diagnosis are more exact and those of treatment are more efficient that they have acted in any manner as factors to deter or to diminish the disease. If any conclusion is to be drawn it is that our improved methods of diagnosis have enabled us to discover the presences of the process where it was not suspected to exist and in individuals who did not present the signs or symptoms of the disease. It is his very art of determining its presence that has enabled us to note both its distribution and its dissemination in every portion of the world. The latter is so great that but very few isolated spots can be found where it does not exist. In fact, there are those who state that a spot free from it does not exist. We are continually reading of the discoveries of travellers in far-off lands and they never fail to remind us of the fact that they have met natives who were luetic. It has been very aptly said that wherever the white man has set foot syphilis sprang up and grew. This may partially account for the wide dissemination of the disease. Be

this as it may, we know today that this disease is the most widely spread of all infections and we also know as well that it is no longer as destructive in its effects as in the sixteenth century.

The nature of this disease is one that gave rise to many theories and conjectures in early times. Looked upon at first as a chastisement of the Lord visited upon disobedient or negligent mortals and then attributed to the malign influence of the stars and of the planets all the various ideas of superstition and magic had their sway for a certain length of time. All probable methods of possible infection were given and dark hints were thrown out concerning various sorts of evil influences and impossible explanations were given not by astrologers and thaumaturgists, but by the physicians of the day who seemed to be at their wits' ends to account for the cause and beginning of the dreaded plague. The nature of the disease was not understood and while its it was known very early that mercury was the sovereign remedy, it was at first employed in a brutal manner and then in a haphazard one. The disease was really so little known and its nature so little understood that we smile today at the vain speculations of the earlier writers. And yet, it is these blind attempts that led to the brilliant discoveries of Hunter and of Ricord who were the pioneers in the vast and interesting study of syphilology. The nineteenth century was, in reality, the birth period of this great study.

For many years it was the aim of the medical profession to find the cause of this disease. At one time its contagious nature was strongly denied and it took some time to establish the fact that it was infectious. This point was finally settled by Ricord who practiced his inoculations for a period of years and succeeded in establishing the fact not alone of the infectious nature of syphilis but of the additional one that chancroid was a local infection in contradistinction to the one that syphilis was a generalized and constitutional disease. Then as formerly the infecting agent was called a *virus* which denomination is still affected to this day by some writers. The time was not long before a new advance in medicine took place and we were soon given the results of the work of Pasteur and others which plainly demonstrated to us the existence of bacteria and this lead to further research and discovery which finally culminated in the addition of a new branch of research in medicine—bacteriology. This led many to look upon syphilis as a bacterial disease and we were given many causative bacteria of syphilis, none of which proved satisfactory until the epoch-making discovery of Hofmann and Schaudinn who found the spirillum which today is the acknowledged cause of the disease—the spirocheta pallida or treponema pallidum, as it has pleased some to call it. This has certainly placed a new complexion on the entire subject of syphilology and has planted it upon a surer and more satisfactory basis. In other words, it has made a scientific study and not one based upon presumptions, as it had formerly been. It endowed it with the quality of certainty and today we are furnished sufficient reliable testimony to be enabled to depend upon it. This, despite the fact that claims have been made of the discovery of certain protozoa which are advanced as the true causes of syphilis and as carriers of the spirocheta, in this manner accounting for the universal distribution of the spirillum. This last claim has not found the support that it would have had, had it been satisfactorily proven, and we are left in *statu quo ante*, until better and more convincing proofs are forthcoming—or, at least, better than we now have.

Some questions of interest are included in the methods of infection which are daily brought to our notice. As is well-known, these modes may be divided into two classes —immediate and mediate. In both there must exist a direct contact with the infecting agent. In the former, this agent has its habitat upon the person, or a portion of it, of the active infecting agent. In the latter, it has been deposited upon some indifferent object which simply act in the mechanical role of a carrier. In either case the active organism is present and then becomes the active infecting agent, if the soil be proper and the conditions are favorable to produce infection. It would simply be a matter of supererogation to cite examples of these means of infection. They have been sufficiently recounted and histories have been furnished in sufficient number to make the matter not alone well understood but familiar to all as well. What concerns us more particularly, in this matter, is the question whether these infections were venereal or not. It is not presumptive evidence of venereal infection when the one carrying the infectious material is an individual of a sex opposite to that of the one who has been infected. To cite an illustrative case: A man affected with mucous patches of the lips and mouth is guilty of assault and battery on a woman. In the course of their altercation, he bites her on the wrist; in due course of

time she presents a chancre at the site where she was bitten. It is a sore that is slow to heal and about two months later, she presents a typical papulo-pustular syphilide. To mention another case: A prosperous merchant had a quarrel with one of his customers, who at once resorted to fisticuffs. The former, being physically the superior of the assaulter, was bitten by the latter on the left side of the neck. This was dressed with an antiseptic; but, in three weeks a typical chancre had developed, followed by a classic syphilide, roseolar and papular in type. In the two examples, which have been outlined there was certainly direct or immediate infection and it certainly could not be contended that any venereal condition was present. Medical literature teems throughout its pages with the recitals of cases of an analogous nature. The results that follow are all of one kind and we must call attention to the fact that the disease which results from these infections does not differ, in any of its essential characteristics, from any other mode of infection and the ultimate outcome is the same. There is an idea prevalent that a chancre, resulting from a bite, is usually larger than one from another sort of inoculation. This is partially true when we consider that the size of the chancre is largely dependent upon that of the lesion which was infected. Chancres from bites have been recorded, which varied in size from a split pea to a silver half dollar; and, on the other hand chancres from venereal infection have been noted as large as a silver dollar. Another belief, that is not supported by facts, is that a chancre resulting from a bite is more destructive in its nature than any other sort. It may be so, apparently, if the bite has been deep; but, essentially it is not and is, in reality a syphilitic infection with a small degree of other bacterial infection. But, this is not a necessary concomitant. It may be well to state that chancres and luetic eruptions are found in those whose nature is moral and whom any observer would see were lesions that were non-venereal. The large and interesting chapter of syphilis insontium or syphilis of the innocent has been very fully developed in the book written by Lucius Duncan Bulkley, of New York. In this work he has presented us with a classic, that has been translated in all the modern languages, and which has given the greatest impetus of any book in the search for extragenital chancres which, we may say, *en passant* are not always non-venereal, by any means. It is a fact, however, that a large majority of cases of syphilis in the innocent are non-venereal in the true sense of the expression. These facts necessarily lead to the general classification into venereal and non-venereal. The cases of the latter are so numerous that there is scarcely a physician who has not observed one or more cases of the sort. It is almost a matter of common observation to note a chancre upon the lips of a *virgo intacta*, the lesion having been acquired from the kiss of a brother affected with buccal or labial mucous patches. Such cases occur through the negligence of the physician treating the infected individual and forgetting to warn him against kissing those who are sound and healthy. This is a method of prophylaxis which is not sufficiently enforced or practiced. A neglect of observing due and proper precautions is always followed by disastrous results. In the case of an innocent female, she hesitates to consult a competent physician; and, as in the weaker sex syphilis is often manifested by rather insignificant constitutional symptoms, she lives in a fool's paradise, unaware of the fact that she is herself a focus of infection. The evidence of this is furnished, at a later time, when miscarriages take place, or when a child is born, who is the carrier of the lesions of prenatal syphilis. Her disease was non-venereal, and the same may be predicated of that of her child—it is more than probable that her husband is also syphilitic and, naturally ignorant of the source of his infection. All of which furnishes an interesting short chapter to the subject of the deontology of syphilis. The consideration of the modes of injection of syphilis in these cases in which the venereal factor does not enter shows that these methods are divisible into two classes. Those in whom the infection has been accidental, and those in whom the infection was intrauterine. It may be objected to the latter that the male sperm cell infects the female germ cell, at the moment of conception. This is a question which is purely academic and may furnish much food for discussion. It is one that is rich in theoretic material and furnishes much food hypotheses. But, what we require, nowadays, is demonstration and proof and this latter must be irrefutable, in its nature, to establish a principle in a manner that cannot be overthrown. The fact of the existence of syphilis may be established by irrefutable evidence; the manner in which it was acquired, is a more difficult matter to establish. The only thing that may be established, chiefly by presumptive evidence, is whether the infection was venereal or not. In some cases the

evidence that is adduced is positive, beyond all doubt. In others there always exists a little room for some justifiable doubt.

The laity, in general, and many medical men as well have either forgotten, or have never known that syphilis is not necessarily acquired by other means than by sexual congress. The disease has been characterized as "bad" or "shameful" such as it was considered in the days of paganism. Then, the sexual organs were called the shameful parts, and any disease which affected them was called a shameful disease. This method of denominating these affections has persisted to this day, but the name has become over comprehensive in that it includes all the other symptoms and complications which may occur, either as direct results of the original infection, or as intercurrent or accidental complications. An example of this has occurred in my experience in the case of an unfortunate individual who acquired a chancroid. Some few years later he had his nose accidentally broken and the wiseacres sagely shook their heads and spoke learnedly of his "saddle-back" nose which was always an infallible sign of syphilis. It is for reasons of this sort that the societies begun, which have for their object social and moral prophylaxis of venereal diseases, have failed. The innocent are branded with infamy and most naturally resent such treatment. The result is that they become active opponents to a movement that should really be encouraged. No one possessed of any ideas of justice and society will tamely submit to such a stigma and in self-defense, will actively oppose a really worthy and beneficent effort. Another reason for the failure of this movement lies in the attempts to subvert the natural laws which govern the genesic impulse and the almost uncontrollable desire to obey its behests. Another reason for the failure of the prophylactic movement lies in the fact that an attempt has been made to attain the impossible. The attempt to render males more or less absolutely continent is simply a dream, as much as is the futile effort to accomplish the complete abolition of prostitution. So long as the sexes exist, erotic impulses will manifest themselves; and, if there should exist but one sex the solitary vice or unnatural practice will prevail to a greater or less extent. All those who have paid a little or any attention to this question know the truth of this deplorable fact. If there be other individuals available for use, either human or animal, it may be accepted as a corollary that they will be made useful by sexual perverts. But this question is such a broad one that it is best left alone here and sent back for its discussion to its proper place.

The legal question of the suppression of all venereal diseases is one which is full of difficulties in its discussion. The very assumption of the suppression of these diseases carries with it, necessarily, the suppression or destruction of the individuals who are the carriers of them. It is obvious that any law contemplating such an action could never be enforced, if it ever could find its way on the statute books. How many of our law makers can honestly aver that they have always been free of any and all venereal contamination? He will admit that this is a privileged question and on that account, will not insist upon an answer. Here we already meet with an obstruction. The physician who treated the infected individual may be able to answer the question, but he will not do so, as the question of privilege surges up here.

One of the subsidiary problems to the suppression of venereal diseases is, necessarily, that which involves abolishing prostitution. This has been essayed for centuries and, it was finally decided to be impossible. The nearest to this much desired consummation has been found to lie in its regulation. One of the disadvantages of regulation is that it does not regulate. It is a method that is much better *de jure* than it is *de facto*. In other words, the statutes are excellent, but their enforcement has been found well nigh impossible and this latter has been found to be due to the increase of clandestine prostitution which is, beyond all question the most prolific cause of venereal diseases. One of the great drawbacks connected with effective laws is the impossibility of enforcing them as they should be.

The venereal peril has led to the development of the great "white plague." But, we are at once led to the question as to whether it is not more important to suppress or, at least, regulate the great white way. The attempt to suppress it would only be cutting off one of the heads of the hydra and have twenty new ones to take its place. We cannot stop to deal with theories; what confronts us are conditions. The Japanese have attempted to limit prostitution by their system of segregation. They have established the Yoshinara and, despite this, clandestine prostitutes swarm in the large interior cities. A hot-bed of venereal diseases is Hamburg and, it is a well-known fact that this city has the best system in the world for the regulation of prostitution. So that, we are almost forced to the con-

clusion that prostitution is an institution that must be dealt with in a manner that is practical in order to be efficient in its effects. The idea of enforced chastity on males and females is simply an impossibility and segregation for the purpose of enforcing it would also be a fruitless effort that would culminate in nothing but imbecility or insanity. So that such a method, far from producing an improvement in conditions, would simply make them worse. The problem is a pretty one and exceedingly puzzling as well. It is one that demands a complete change in social conditions by the adoption of means, which are not considered exactly proper, at the present time. It involves proper moral rearing of children and of adolescents and by this is meant keeping them away from evil surroundings and companions. It also includes early teaching in sexual matters, in a manner to give correct ideas and divest them of all thoughts of pruriency or indecency. It is the abandonment of all prudery that constitutes one of the chief elements of success. Divest all conversations and teachings of this element and the young minds will no longer harbor thoughts that cannot be expressed in the family and, as a natural consequence, the younger members will have healthy minds. All impulses to be everything but clean and proper will be abandoned. The result will inevitably be that the younger generation will be sound in mind and body and these young people will enjoy more good clean literature than the most thrilling pornography.

To come back to our subject. The absolutely venereal origin of syphilis is far from having been proven. The examples which we have been mentioning of accidental infection, the well-known cases of prenatal syphilis and those of innocent infection, of wives, sisters, or other near and dear relations are sufficiently numerous and observed often enough by physicians, in the course of their practice, to fully establish the fact that such infections are not venereal in their origin. It is sufficiently depressing to the victims to know that no such condition existed, although this is, in reality but a very poor consolation, when the actual damage that has been done is considered. That the writer is not alone in his contention that syphilis is not always of truly venereal origin, is attested by the best and greatest veneologists that have written on the subject. There will be no attempt made to give a syllabus of authors who have published such ideas, but a few quotations from the last edition of the book of Sir Jonathan Hutchinson, the celebrated English syphilologist will be given as evidence of the opinion of this safe and sound as well as conservative author. We find the following at the very beginning of his book (Syphilis. London, 1910, page 9 *et seq.*): "In order that we should understand syphilis, it is necessary to recognize that it is by no means essentially a venereal disease. Its various phenomena result from the introduction into the patient's system of a specific poison; and this poison, in all probability, consists of particulate and living elements.* It can be conveyed from one person to another only by direct contact of surfaces. The thinner and more delicate the tissues exposed to its contagion, the more easy is the implantation of the virus. The existence of cracks, abrasions, or ulcers, although probably by no means essential, much favors the success of the contagion. It does not matter in the least upon what part of the body the contagion is effected; for syphilis is always one and the same disease, and is modified in its course only by the inherent peculiarities of the person acquiring it, and the antidotal drugs which are used. It is obvious that the venereal act affords peculiar facilities for the transference of a virus of this kind, needing direct implantation upon delicate tissues. Hence the fact that syphilis, as seen in England, is in the great majority of cases communicated in this way, and hence its peculiar synonym. We meet, however, in practice, with numerous cases in which the contagion takes place upon parts distant from the genitals: on the finger, as so often seen in medical men and midwives; on the lips, from kissing or from the use of contaminated pipes or drinking vessels; in the sores produced by vaccination, and, in fact, upon any part of the surface which has been by accident inocculated. The study of some of these cases is of even greater value than of those in which the disease is received in the usual way, since the dates can be more accurately fixed, and it also sometimes occurs (as in the case of syphilis by vaccination) that a number of persons receive the disease on the same day and from the same source. When these accidents happen we have exceptionally good opportunities for observing the natural development of the malady." In speaking of non-venereal true chancres the same author says (*Ibid*, page 21): "These are much more common than is generally suspected. They are of great importance, not only on account of the social injury, which

*We may now believe with considerable confidence that the protozoan parasite discovered by Schaudinn is the element concerned.

errors respecting their source may cause to the individuals, but also for the mistakes to which they may lead in clinical observation as to the course of syphilis. . . .

The diagnosis of these is often extremely difficult."

The same author goes on to say (*Ibid*, page 35): "In tropical practice, where non-venereal chancres are very common, not a few originate from insect contagion, mosquitoes and fleas are more especially to be suspected. The form of syphilis which goes under the name of "yaws" is probably, as a rule, originated in this way. In England I have on several occasions had reason to suspect communication of syphilis by fleas. A case in which the evidence seemed almost complete was that of an elderly medical man who came to see me with an unquestionable secondary eruption. He was married and denied any exposure to risk. He submitted willingly to the inspection of all parts of his body. Nothing in the least suspicions could be discovered, excepting a small rusty patch on one leg. This, he said, was the remains of a papule which had followed the prick of a flea which he had acquired in an omnibus. He well remembered the occasion, for the prick had been attended by great irritation, and the date fitted with the suggestion that this had been the primary sore." Again (*Ibid*, page 36): "The occasional association of syphilis with scabies is of more importance than may appear at first sight. The two diseases may be caught on the same occasion. The coincidence may not only explain the occurrence of itching syphilitic eruptions, but may not improbably be the factor in many cases of erratic and unexplained contagion. A patient with the syphilitic virus in his blood and a scabies eruption on his skin may become a most serious source of danger to those about him. Such an eruption would be attended with far greater risk of communication to others than an ordinary secondary rash." Chancre in connection with lice is thus animadverted upon by the same author (*Ibid*, page 38): "A man, usually continent, went astray with a common prostitute in Marseilles. It was a single occasion. He was a medical man, and, naturally, very anxious as to what might happen. He soon found that he had contracted lice, and he shaved his pubes and applied ointment. Nothing whatever appeared on his penis, but a small sore which he attributed to the parasites formed into the skin of the abdomen amongst the pubic hair. This sore never indurated in the least, and was never larger than half a pea. Soon after it was observed, a hard gland was noticed in the corresponding groin. As the sore did not harden, its true nature was not suspected and no special treatment was adopted. In course of time a very abundant roseolous eruption covered the whole trunk. . . I think it very probable that the infecting sore (the chancre) in this case was caused by the puncture of a pediculus freshly arrived from a syphilitic hostess."

These few quotations from the latest work of Sir Jonathan Hutchinson are given because they reflect the opinions of the most prominent English syphilologist, and the later writers on the subject will be found to agree with him. It is unnecessary to multiply authorities and their dicta in regard to the question. With a very few exceptions, they are of one mind, in their conclusions. It is our duty, in all cases of acquired syphilis, to determine as far as possible, the mode in which the infection occurred. This involves the further search into the possibility of the story that is given to us. It is a difficult matter, at all times to establish a venereal origin, in the case of females. Males are not so chary in affording information; although, in the case of married men, it is often a difficult matter to establish the origin of a case, and especially so if the individual is one who travels much and has not a fixed abode. It is true that some are truthful in their accounts and then it is that much research as well as ingenuity must be brought to bear on a case, in order to arrive at a satisfactory conclusion. Persistence and the recollection of analogous cases will do much in the matter of clearing up an otherwise obscure case. Such a condition of affairs is always interesting and the final clearing up of the matter is one that is always attended by satisfaction of a more or less complete character. We find, in every such case, many points of interest and such as are profitable as well as entertaining. Such a condition of affairs has a tendency to broaden the mind as well as afford good opportunities for observation as well as a chance to draw deductions, in a logical manner. From what has been said in this paper, it should be obvious to anyone who has paid but some little interest and attention to it that the mere fact of the existence of syphilis in an individual is no indication or presumption whatever that it is venereal, or was accquired in the act of sexual intercourse. This is but too often the gratuitous assumption of the laity and of a large proportion of medical men. There seems to be too much of an idea that human beings are naturally depraved and that the idea or sole desire of every indi-

vidual is to indulge in this practice of sexual or carnal intercourse for the satisfaction of animal passion; or as one has expressed it, for the exercise of the functions of the sixth sense.

808 Times Building.

FAMILY-PHYSICIAN REFRACTING AS A FACTOR IN MEDICAL PRACTICE, AND ITS PROMOTION DURING 1910.*

LEARTUS CONNOR, M. D.

DETROIT, MICH.

During the meeting of the American Medical College Association, March, 1910, Augustus S. Downing, M. A., Ph. D., LL. D., executive head of the New York State Educational System, announced the establishment of a chair of optometry in Columbia University, to be filled with a non-medical man. Noting the surprise of a physician listener, he added: "You know that refracting is not a part of medical practice."

This position is easily comprehended when we recall that Mr. Downing's ideas on this subject originated with Mr. Charles F. Prentice, president of the New York State Optometrical Board were transmitted by him to President Butler of Columbia University. This university conducts a medical school with a distinguished reputation of more than an hundred years, the maintenance of which demands that future graduates be adequate, for the broadest medical service of the people—a service impossible without a "working knowledge of refracting." When optometrists urged the University to establish for them a "Specialist Refraction School," we should have expected that it consult its medical faculty and make no move hostile to its existing school. Surely it would stipulate that only physicians be admited to the proposed school of "specialty refracting," and arrange that the scheme be so developed as to train physicians able to manage any eye case, from the point where family physician limitation left it, with an exhaustive equipment of all known facts in literature, laboratory, hospital and operative technique. Instead of taking this logical course in the contest between physician and optician for the control of medical refracting, Columbia University threw her vast influence with the optician.

The optometrists persistently claim that they do not invade medical practice, in that they refract without the use of drugs. By persuading the people that this claim is well founded, twenty-four legislatures have legalized their refracting—so that laymen now practice medicine, in spite of medical acts.

By the same process the optometrists expect to capture all of ophthalmology. Thus in an address before the Tennessee Optical Society Mr. R. T. Hudson, an optician (Cincinnati Lancet-Clinic, June 10, 1910, p. 102), says: "The greater part of ophthalmology is eye diseases and their reflexes. Here is another field to exploit, and we propose to invade it, and not only to invade it, but to capture it. Nor do we intend to stop here. There is still another field to invade and it shall be ours, namely, ophthalmic surgery."

The facts prove that not a few doctors get their refracting done by opticians and advise their patients to do likewise—showing their belief that medical knowledge is not essential to refracting.

Few medical colleges so teach refracting that their students can practice it with satisfaction to themselves or patients. Of the forty-two state medical examining boards, only four make a working knowledge of refracting a condition for license. Nor is the spirit of college teachers and the general profession such as to inspire that enthusiasm, necessary to overcome the inherent difficulties of refracting. Considerations like these indicate that refracting is not seriously regarded as a factor in medical practice, worth attention by others than ophthalmologists.

Yet the eye is a part of the human body. Without the labors of Helmholtz, Donders, Snellen, Liebreich, Von Graffe and other doctors there would be no scientific refracting. Thus, though discredited by the profession's failure to master it, refracting is an essential part of the practice of medicine; because it concerns an important organ in the human body, the eye; because doctors have worked out eye structure and function, normal and abnormal, the methods and instruments needed to determine refractive defects and make an exact correction thereof; because doctors alone can fully appreciate the disorders that refractive defects may induce in the structure and functions of organs far distant from the eye; because every treatise on general medicine refers to refracting as an important aid to the diagnosis, prognosis and management of many disorders; because every text-book on the eye gives large place to refraction, explaining its nature, methods

* Read before the Michigan State Medical Society, September 28, 1910.

of study and use of apparatus for diagnosis and treatment. These and allied considerations, establish refracting as an essential part of general medical practice and indicate that every family doctor should be as able to refract all his simple cases as he is to manage cases of simple surgery, obstetrics, internal or external disease, or other simple human disorders.

Yet the most superficial inquiry demonstrates that such family physician refracting is the exception. Thus of the 135,000 physician in the United States, the most careful study fails to find above 3,000 able to refract, or one in forty-five.

Then considering refracting from the point of the people's needs, we find: 180,000,000 human eyes in the United States, each of which after forty years needs refracting, most many times. Before forty years the myopes and hyperopes, call for refracting one or many times. Granted that half of the people needed such service before forty years, we would have 270,000,000 of human eyes needing refracting. Assuming the present number of refractionists as 3,000, each would have the job of refracting 90,000 eyes—an impossible task. But if our entire 135,000 physicians refracted their own simple cases, each would have about 1,000 refraction cases.

Facing this condition, only two courses are open to the profession, viz: Either qualify all its members to do their own refracting in conjunction with ophthalmologists, or leave the matter in the hands of opticians. Since the latter course connives at the admission of laymen to medical practice without a medical education, friends of the medical profession must reject it and accept the "Michigan idea" to qualify every physician to do simple refracting. Farther, as we have seen, submission to the rape of medical practice by opticians will greatly impair the force of existing medical laws and invite the invasion of other branches of medicine by non-medical persons. At this juncture to protect professional interests, the Michigan State Medical Society started an educational movement to qualify physicians for simple refracting. At last year's meeting the progress of this movement was reported briefly as follows: The Michigan State Board of Registration, had notified medical colleges that after February 12, 1909, it would require for license a working knowledge of simple refraction. Many medical colleges whose graduates were likely to seek a license to practice in Michigan began qualifying their students for such requirement. Dr. Hubbell, chairman of the Ophthalmic Section, American Medical Association, presented the matter in his annual address. A section committee on this address reported that "every practitioner should be able to manage refractive defects of the eye and its infectious disorders." This report was adopted by the section of eleven hundred ophthalmologists, and a committee appointed to promote such education of the profession; the committee was Leartus Connor, Detroit; James Thorington, Philadelphia, Pa.; and Albert R. Baker, Cleveland, Ohio. Reports from family physicians in Michigan were read, showing that they had mastered and were practicing refracting.

During its second year, 1910, the family physician refracting found promoters in many states. Circular letters were sent to registration boards, to some medical journals, to influential doctors, asking that State registration boards require simple refracting as a condition for, license. Various other methods were adopted to awaken thought on the subject, by those concerned in medical registration and education, in the belief that when comprehended all would unite in promoting family physician refracting.

Time forbids more than enumeration of the milestones passed by the movement during 1910.

1. Vermont, Nebraska and Utah have joined Michigan in requiring, for license to practice medicine, a working knowledge of simple refracting. It follows that the medical colleges, whose students desire to practice in those states, began to prepare their students for such examination.

2. Last fall the Kentucky State Medical Society endorsed the Michigan idea.

3. On invitation, a member of the committee read a paper before the Association of American Medical Colleges, at its meeting last March on "The Economic Value of Simple Refracting," and other members discussed it.

4. On May 3, 1910, the Detroit Ophthalmological Club invited to a conference on the "Economic Value of Family Physician Refracting," officers of the Michigan State Medical Society; officers of the Wayne County Medical Society; officers of the Michigan State Board of Registration; the deans of the Medical Department of the University of Michigan and Detroit College of Medicine, and family physicians doing simple refracting. After several hours of frank discussion, the movement was unanimously endorsed and fitting resolutions adopted, on motion of Dr. Don M. Campbell.

5. On June 6th, the American Academy of Medicine unanimously adopted the fol-

lowing: "Whereas, The refracting of human eyes is an important part of medical practice:

"Whereas, The physicians now qualified therefor, are quite inadequate for the people's needs: "Whereas, The Ophthalmic Section of the American Medical Association says 'That relief from this inadequacy is possible, only by training our 135,000 physicians to 'manage infectious diseases of the eye and its refractive defects:' "

"Resolved, That the American Academy of Medicine:

a. Recommends medical colleges to arrange a curriculum that will equip their students with such training.

b. Approves of those state registration boards now requiring it for license; and

c. Advises like action by other state registration boards at an early date."

6. On June 6, 1910, Dr. Herrick T. Vail, professor of Ophthalmology in Cincinnati University, read a paper on "Family Physician Refracting" before the National Confederation of State Medical Examining and Licensing Boards. After a full discussion, the following was unanimously adopted:

"Resolved, That the National Confederation of State Medical Examining and Licensing Boards:

a. Recommends medical colleges to arrange a curriculum that will equip their students with such training:

b. Approves of those State registration boards now requiring it for license; and

c. Advises like action by other State registration boards, at an early date."

7. On June 9th, 1910, the House of Delegates, American Medical Association unanimously adopted the following:

"Resolved, That the House of Delegates of the American Medical Association:

a. Requests its 'Council on Medical Education' to arrange a curriculum able to equip medical students with such training as will enable them to manage infectious diseases of the eye and its refractive defects and recommends medical colleges to adopt the same.

b. Approves of the State registration boards now requiring it for license;

c. Advises like action by other State registration boards at an early date.

8. On September 22, 1910, the American Academy of Ophthalmology and Oto-laryngology, at its meeting in Cincinnati, O., adopted the following:

Resolved, That every family physician should have a working knowledge of simple refracting and be able to manage infectious eye diseases; that this knowledge should be taught in medical schools and required for license by State medical registration boards.

9. Not a few medical journals printed and favorably commented on the plan of the committee to encourage the requirement of a working knowledge of simple refracting for license. Among these we note an editorial in the Boston Medical and Surgical Journal of December 9, 1909, and one in the Medical Fortnightly of St. Louis, Mo., as especially forceful.

10. Among numerous letters from leaders in the profession endorsing the movement were those from Dr. William G. Gorgas and Dr. C. A. L. Reed, both expresidents of the American Medical Association. Dr. W. W. Grant, trustee of the Journal of the American Medical Association, writes from his Denver home, "that the action of the Michigan State Board of Registration (in requiring for license, family physician refracting) is both wise, timely and greatly to its credit."

Remembering, that two years ago, the 135,000 physicians in the United States doubted the possibility of family physician refracting; that few medical colleges tried to teach it; that no registration board required it for license; that no medical journal or society advocated it, our present condition speaks volumes for the Michigan State Medical Society's grasp of the profession's needs and its tactful energy in promoting their supply.

It is suggested, that every doctor hang in his office, a Snellen test card, and lay upon his table a copy of Jaeger's test types. The use of these in all cases of doubtful diagnosis will surely promote his knowledge of and confidence in the helpful power of simple refraction by family physicians. As the art becomes easy, there will accrue an increased intellectual power; larger influence over patients and the community; more successful results in other than eye cases; broader and more correct views of general medicine; and larger financial rewards. Verily family physician refracting is the key to a vast professional uplift. It is respectfully urged that medical colleges drop the vain attempt to teach undergraduates operations on the eyeball, which no family doctor can perform, and devote the time and energy thus saved to training each student to do family refracting with comfort to himself and satisfaction to his patient—in short, train the student in the things that he can practice, and omit the things he can never hope to do.

Finally: 1. The spectacle lens can cure many human disorders.

2. The ability to prescribe such lenses correctly is a part of medical practice.

3. Neglected by medical schools and the profession, refracting fell into the hands of opticians.

4. With the enactment of medical laws for physicians, opticians sought like government protection of their medical practice, on the double plea of insufficient refractive service to the people by physicians and their ability to refract without the aid of medicine.

5. In 1908, the Michigan State Medical Society started a movement for qualifying every doctor to do his own refracting (by the aid of ophthalmologists), thus satisfying his patients before they seek an optician.

6. The attainment of this object is beset by many obstacles, because it is a new idea projected into medical practice but present success presages its final triumph.

91 Lafayette Boulevard.

OBLITERATION OF DRUG CRAVING.

WILLIAM F. WAUGH, A. M., M. D.

CHICAGO.

Denn and Professor of Therapeutics, Bennett Medical College.

During the twenty years I have been studying drug habits I have given trial to every method, every remedy, that have been suggested for the treatment of these affections. Every secret method that has been heralded in the press, with sweeping claims of impossible or even miraculous cures I have likewise investigated, not because I believed the preposterous claims made in their behalf but that I might not lose whatever kernel of true value there might be in the chaff of deceit.

Several times I have been led to believe I had discovered the true specific, each time to find that it was only specific for a certain group of cases presenting a particular clinical picture. When I formulated the hypothesis that the craving for morphine was due to toxemia, the poisons stored in the body cells being let loose into the blood when the inhibition of morphine was lifted, I believed that at last the secret was discovered. I still believe it; but as to the details of application I am free to confess that I have yet somewhat to learn.

For some years I have mainly relied for elimination upon emetine, salines, and a little calomel, with an occasional dose of pilocarpine. This has been more successful than any former method, and I have not a failure to record; but some of the patients suffered more than was agreeable to them or to me; though most of them acknowledged afterward that the suffering was not serious enough to warrant complaint. Still, I was not satisfied.

An old dentist in Ohio had a secret method that was quite successful. He purged his patients powerfully with compound cathartic pills—and that was all. I tried the quick method on some men but it failed because the craving for morphine was incessant, and the purgatives set up an enteritis that inflicted more suffering than was justifiable, continuing for nearly two weeks.

In September, 1909, there appeared in the Medical Record an article which gave the details of a method by which the patient could be "cured" of morphine, cocaine or alcohol addiction in three days. This consisted in the use of c.c. pills, U.S.P., and a still more powerful purgative containing podophyllin and croton oil. At the same time a specific remedy was employed to abolish the craving for the habit drug. This specific consisted of two parts tincture of belladonna (15 per cent), and one each of the fluid extracts of xanthoxylon and hyoscyamus. Of this mixture six drops were given every two hours, rising to 16 drops or until decided evidences of toxic atropine action were manifest. The purging was kept up until free bilious stools occurred, when the cure was considered complete.

I have given this method a trial in one case: October 14, the patient began the purgatives in the morning, taking at the suggested time one-half her daily allowance or 2 grains of morphine. October 15, she continued, taking one grain of morphine. October 16, she took three grains of codeine phosphate; and at 6 a.m., October 17, one grain codeine phosphate.

She has not suffered the usual withdrawal symptoms at all, the only suffering of any sort being when I gave her the more irritating cathartic, which was the reason for taking the second dose of codeine. During this day she was about the house, did the light housework necessary, but felt to the full extent the sense of powerlessness common to those habituated to work on morphine. While taking it she was tireless.

Whether a cure resulted in this case I am not ready to decide. It will depend on my ability to keep up her strength and convince her that life and its duties are possible and desirable without morphine. The tonics advocated by Dr. Lambert,

strychnine, digitalis and strophanthus, are not applicable in this case. Strychnine always overacts with her disagreeably in doses that act at all. Her heart-action is not such as to indicate the need of any form of cardiant—with normal heart-action no benefit can accrue to heart-modifiers for which there is no indication. The symptom demanding relief is muscular weakness, and for this caffeine valerianate seems nearest the indication. The severity of the elimination is evidenced by her hollow face and loss of embonpoint.

The result in this case has been exceedingly gratifying. There is very great value in the method; yet it is not all, by any means. Croton oil is too harsh for these patients, whose intestinal mucosa has been long saturated with the decomposing products of retained fecal masses, and is prone to fall into a form of inflammation very difficult to handle. Yet this has been restrained by the specific in a way I should scarcely have believed possible. The final dose of castor oil is not nearly so effective as a full dose of pure emetine, nor as likely to be retained by the stomach.

The belladonna and hyoscyamus could be replaced by amorphous hyoscyamine, which contains a large percentage of hyoscine. The effects noticeable are those of the atropine group. No evidence of any effect from xanthoxylon was perceptible, but cases treated without it may not do so well. This remedy is practically an unknown quantity.

It did not prove necessary to push the specific to the induction of flushing of the face or dilatation of the pupils; the desired benefit was secured when the mouth became dry and the speech showed the peculiar sharp, incisive quality mentioned by Dr. Lambert.

I must agree with him that this is not a method by which anybody, even a physician, can cure himself at his own home without assistance, even if he suspends practice. I would not even advise the doctor to try it on his own wife; for there is always a time in the cure when the patient's judgment is not a safe guide, or his resolution to be trusted. At this time the propriety of attempting a cure becomes questionable, and if left to himself the patient will surely take the drug, though there is no reasonable excuse for it. But so powerful is the hold that morphine exerts upon its victim, so deeply does it insinuate itself into his soul, that he will be persuaded by this possessing demon that it is his duty to take the drug. During this period the patient must be under the control of others, and these must be persons fully aware of the true conditions and able to cope with them.

CORRESPONDENCE

MUST HAVE A WIDE CIRCULATION.

Holland, Texas, September 6, 1910.
Dr. T. A. Hopkins,
Editor Medical Fortnightly,
St. Louis, Mo.:

Dear Doctor: I have a paper on Spinia Bifida, with report of cases, which I read before the Central Texas Medical Association recently. A great many of my medical friends have asked me for reprints of the paper, so I thought I would offer it to you for publication. I have some drawings showing types of tumor and the steps of operation. You remember publishing my paper last year on the "Repair of the Female Pelvic Outlet." I received several hundred letters from different parts of the country in regard to this operation after you published my paper, and for this reason I am inclined to think your journal must have a very wide circulation. Should you wish to review my paper, let me know and I will send it to you.

Yours very truly,
W. L. Crosthwait, M. D.

A Campaign Against the Public Drinking Cup.—The Cup-Campaigner is the name of a little pamphlet published at intervals in New York by persons who "are striving to banish that most prolific medium for spreading disease—the public drinking cup." The second number of this publication is dated August, 1910, and consist of twelve pages. It contains reports of the rulings of health officers in relation to the public drinking cup, the growth of public sentiment against its use, and other developments of the crusade. Laws have been passed in seven States enabling the State Boards of Health to prohibit the use of public drinking cups in every schoolhouse, railroad train and station in the state. These States are Wisconsin, Michigan, Kansas, Missouri, Oklahoma, Massachusetts, and Iowa. Its use has also been prohibited in every schoolhouse in California and in the State Capitol at Harrisburg, Pa. Forty State Boards of Health have decided that the public drinking cup should be abolished.

THE MEDICAL FORTNIGHTLY

Issued Tenth and Twenty-Fifth of Every Month

THOMAS A. HOPKINS, M. D, Editor

EDITORIAL ASSOCIATES;

DR. R. B. H. GRADWOHL, St. Louis
DR. C. W. HEPBURN, Philadelphia
DR. A. F. KOETTER, St. Louis
DR. O. E. LADEMANN, Milwaukee

Editorial Rooms, Suite 319-320 Century Building, St Louis, Mo.

EDITORIAL

Something Further of "606."

Most gratifying reports continue to come to the profession relative to the phenomenal efficacy of the long-desired specific for syphilis. It seems from these reports that it has been conclusively established that in arseno-benzol, arsenphenol-amin or "606," as it is variously called, syphilis is to be robbed of its terrors. Time alone can demonstrate the permanence of its curative effect, but the speed with which aggravated symptoms vanish under its influence augurs well for its position.

Scientific reasons have been advanced why this remedy is not to be immediately placed upon the market, reasons which appealed to the judgment of those who have often been disappointed in remedies prematurely exploited, but we must confess to having had a degree of apprehension on the subject. It now develops that our apprehension was well founded for we are hearing that the remedy is being completely covered by patents and is to be exploited on a commercial basis—for profit, in other words. We feel that the discoverer of such an important agent merits wealth and recognition, in fact we believe that, should he give his discovery to the profession and the world, wealth would still come to him for the wealthy would want none other than the discoverer to treat them, no matter what charge he might make; as for glory from the discovery, it would be vastly greater did he make this agent available at moderate cost for all who need it, nations would speak to his honor. Nothing which we have seen gives any idea of the probable cost of the agent when it shall be available. It seems regrettable that a remedy of such possibilities for good has to serve a commercial end. It would almost seem that governments should intervene in behalf of their peoples. If it is justifiable to confiscate private property in time of stress for the public weal, how much more to be justified would be the acquiring of such an agent as this, even at tremendous cost, and placing it within the easy reach of all who need it? Instead of this the governments are issuing patents which will, in all probability, place it beyond the reach of the many who most need it. We hope that we are mistaken in the doubt which assails us. We will be pleased to learn that "606" can be administered without disarrangement of fees for those in moderate financial position, and that there will be no occasion to withhold it from those who have to depend upon medical charity. But the talk of patents is not reassuring and we await developments along this line with almost as much interest as we do those which concern its clinical development.

Physiologic Therapeutics.

We have often wondered what impression it would have made on the active physician of three and more decades ago could he have had a glimpse of the present day interest of the profession in drugless therapy; we doubt very much if he would have felt that he could fraternize with those who hold views which are very common these days. Beyond a very limited knowledge and use of heat, water, electricity and dietetics, physiologic therapeutics, as at present understood, is a product of the past twenty-five years. It is proving itself a wonderful realm and they who allow themselves to wander therein are enchanted with its possibilities. Through the study of physiologic processes and of drugless means to encourage their normal action many men who are in excellent standing among their fellows have come to an almost entire abandonment of the use of drugs. We are far from ready to acknowledge that this abandonment of drugs will ever be complete, or that it is desirable, but we know that the profession is to be congratulated that it has reached a stage when the prescribing of drugs is but an incident rather than the prime factor in its calling. Slowly the public is coming to understand that a call from the physician does not of necessity mean one or more prescriptions, and that his bill cannot be reckoned by the prescriptions written. He is teaching them the importance of things other than drugs in the scheme of things healthwise and the time is not far distant when the man who is not well versed in all the various means to the end, health, other than as

well as including drugs, will find himself behind the procession and wondering what has happened.

But the efficacy of drugs is just as real as it ever has been. Drug nihilism is a consequence of ignorance, of incomplete training in that very important branch of medical education. There must be a reversion on the part of the profession, a return of faith; stronger chairs in our schools in medicinal therapy are even a more crying need than is that for an extension of the work in non-medicinal therapy. It is not the fault of medical graduates that they do not know drugs, and consequently prescribe them with misgiving, they have been ready to learn but their time has been fully occupied otherwise and no strong courses have been offered them. A man who does not know his drugs cannot prescribe them effectively. The medical schools are not turning out men who know drugs. Other means in treatment are important, they should be well understood, but the present development of drugless therapy will not let it stand alone and we doubt if it ever will. There is a mutual dependence between the two and each has its own great importance; neither should be relegated to the background in the plan of medical education. The making of a proper diagnosis is an absolute essential to success, but it alone will not relieve the sufferer; arriving at an unquestionable diagnosis may please the physician, but it is mighty little good to the patient if that is the end of your effectiveness. You may use drugs, you may use manipulation, or other means, but its up to you to do something and do it intelligently.

Death of Dr. G. Baumgarten.

A few years since we had in the local profession a number of men who were lovingly denominated "the Old Guard." One by one they were removed and none others have ever seemed to take their place. One's attitude toward age changes as one ages himself, and it comes as something of a shock to have reached that middle span in life when the elders among us no longer seem "old." 'Twas thus that we felt toward Dr. Baumgarten, who died on September 19 at the age of 73. It had never occurred to us that he was an "old" man, or that death could be for him anything but years ahead. Yet the Grim Reaper has taken him and we hear it said that he was advanced in years. Dr. Baumgarten's long and continued activity in medicine made him an important personage in the profession; during his many years he occupied many positions of importance. He consecutively held chairs in the St. Louis College of Physicians and Surgeons, the St. Louis Medical College and the Medical Department of Washington University in the last of which he was incumbent at the time of his death; his career included some years as medical editor, he having edited the St. Louis Medical and Surgical Journal from 1867 to 1871. He practiced continuously in this city from the close of the war to the time of his death and was ever recognized as a scholarly man, an effective physician and a courteous gentleman. He was a pioneer among the internists, as they have lately come to be specialized; he was recognized as an authority among his fellows in this work. His death is a great loss to the faculty of Washington University, to the profession of the city and to the city itself.

Loss of weight in diabetes, in spite of a good appetite, is a bad sign.

Wet or Dry.—The prospect of voting whether or not Missouri shall be wet or dry at the November election is stirring men of every calling to an interest, and they are lining up on either side as their interests and beliefs dictate. Whatever the outcome it is to be hoped that the medical profession will live up to its ideals and reputation as a law respecting and law abiding body. Should the unexpected happen and Missouri go dry, the medical bootlegger will be a natural consequence, the organized profession should be ready to deal with him should occasion arise.

The M. V. M. A. at Detroit.—The meeting of the Mississippi Valley Medical Association, recently held at Detroit, was a scientific treat and a season of genuine good-fellowship but it was, unfortunately, participated in but by a few. We are told that the total registration was but 123. Officers for the ensuing year were elected as follows: President, Dr. Robert H. Babcock, of Chicgao; first vice-president, Dr. Arthur D. Holmes, of Detroit; second vice-president, Dr. Charles E. Barnett, of Fort Wayne, Ind.; secretary, Dr. Henry Enos Tuley, of Louisville (re-elected); treasurer, Dr. S. C. Stanton, of Chicago (re-elected). The selection of the place of meeting and of the chairman of the Committee of Arrangements for 1911 was left to the Executive Committee with power to act.

ST. LOUIS ITEMS.

Dr. A. H. Ohmann-Dumesnil has severed his connection with the St. Louis College of Physicians and Surgeons and assumed the chair of Dermatology in the Barnes medical faculty.

At the opening of the Medical Department of Washington University several additions to the reorganized faculty as previously mentioned in the Fortnightly were announced. Dr. W. E. Garry is associate in physiology; Dr. D. E. Jackson, associate in pharmacology; Dr. G. E. Smith, instructor in pathology; Dr. W. M. Marriott, instructor in chemistry, and R. E. Gessell, instructor in physiology.

The new building of the Barnard Free Skin and Cancer Hospital is fast nearing completion. It is easily one of the show buildings of the city, yet it is being built with the one idea of practical utility. It presents in attractive form many points of modern hospital construction in their highest development along with the buildings of the public schools should be the architectural pride and delight of every St. Louisan.

New Dispensary Established.—St. Louis University has established a free clinic adjoining Alexian Brothers Hospital in South St. Louis. Dr. William W. Graves has charge of nervous diseases; Drs. Harvey S. McKay and Carroll Smith are in charge of the department of diseases of women and surgery; Dr. Clarence Loeb is ophthalmologist; Dr. William M. C. Bryan, otologist, rhinologist and laryngologist; Dr. Charles H. Neilson is in charge of the department of internal medicine, and skin diseases will be treated by Dr. John W. Marchildon.

Glowing Promises Not Fulfilled.—The great difficulty, with many physicians, is to make glowing promises of cures in the case of venereal diseases; and one of the disappointing phases, in connection with these troubles, is that they do not respond to the demands made upon them, by the best and most logical treatment. It is a good mode of practice not to indulge in complicated methods, but rather, adopt such as are simple as well as efficient. Many a patient has been disappointed, by the continued trials of a physician who tries to effect a cure by means of which he has read, but has never used in his own experience. Such methods rarely prove successful, and, but too often end in disappointment for both patient and physician.—American Journal of Dermatology.

THE REVIEWER'S TABLE

Books, Reprints, and Instruments for this department, should be sent to the Managing Editor, Century Building, St. Louis.

Anatomy, Descriptive and Applied. By Henry Gray, F. R. S., late lecturer on Anatomy at St. George's Hospital, London. New (8th) edition, thoroughly revised, by Edward Anthony Spitzka, M. D., Professor of Anatomy in the Jefferson Medical College of Philadelphia. Imperial octavo, 1496 pages, with 1208 large and elaborate engravings. Philadelphia and New York: Lea & Febiger, 1910. (Price, with illustrations in colors, cloth, $6.00, net; leather, $7.00, net.)

The announcement of a new edition of Gray's Anatomy interests every one concerned with medicine, student and practitioner alike, for it deals with the only science entering into every medical question. Henry Gray was a two-fold genius, as he combined a thorough knowledge of human structure with equal insight as a teacher. Neither of these qualities singly could have produced a book in which matter and method were so perfectly welded into an ideal teaching instrument. Gray's inventive mind devised the scheme of engraving the names of the parts directly on them, so that the eye caught at a glance and photographed on the mind their nomenclature, position, extent and relations, the four cardinal points. His work marked an immense advance over its competitors, and sprang at once to the forefront, where it has remained ever since, more than a half century.

This new edition, the eighteenth, is the most thorough of all revisions, every line having been scrutinized for possible improvement, anything in the nature of an obscurity being clarified, and whole passages rewritten. The changes have been so thorough going that the book has been entirely reset in new type. The latest developments in this active science are included, so that this single volume gives a complete account of human structure according to the latest views. The editor, Dr. E. A. Spitzka, is professor of anatomy in the Jefferson Medical College of Philadelphia, and one of the world's foremost anatomists. He is also a competent artist, and the drawings from his hand convey his own accurate knowledge directly to the mind of the student. Many of the former engravings have been replaced and more added, so that the series of illustrations is more abundant than ever before. This applies also to the use of colors. Nothing has been spared to maintain the reputation of the book as being the easiest from which to teach or to learn, and as facilitating to the utmost the acquisition and retention of a sound knowledge of its subject.

The Practice of Medicine. A Guide to Nature, Discrimination and Management of Disease. By A. O. J. Kelly, M. D., Assistant Professor of Medicine, University of Pennsylvania, etc. Octavo, 949 pages, illustrated. Philadelphia and New York: Lea & Febiger, Publishers, 1910. (Cloth, $4.75, net.)

Dr. Kelly is thoroughly prepared for the writing of a work covering the modern practice of medicine. As a teacher he holds a distinguished professorship in the University of Pennsylvania, a position only won by many years of meritorious work, and he has enjoyed even longer experience as a general practitioner. Being chief pathologist to one of the foremost hospitals in America, he is thoroughly grounded in this fundamental science. His purpose in undertaking the great labor involved in writing a comprehensive book on present-day practice is to give the student and junior physician a guide to the nature, discrimination an management of disease, containing the essentials without excess of detail. He has devoted most space and attention to the practical aspects of medicine, to the elucidation of principles exemplified in disease at the bedside, in hospital wards and clinics and in the consulting room, and to symptomatology, diagnosis and treatment. These main objectives are presented in their natural connections by means of brief sections on etiology, essential anatomical lessons and pathological physiology. Such knowledge is essential to a correct understanding of morbid phenomena, to ability to forecast and provide against contingencies, to judgment as to the course, duration and termination of a disease, and to skill in treatment and prophylaxis. Under each disease at least one method of treatment of known value is given, and formulae are presented as an aid to the junior practitioner in times of stress. The reader who masters the knowledge so rationally presented in this authoritative book should have no difficulty in passing his collegiate and State examinations and in proving himself a successful practitioner.

A Manual of Obstetrics. By A. F. A. King, M. D., Professor of Obstetrics and Diseases of Women in the Medical Department of the George Washington University, Washington, D. C., etc. Eleventh edition, enlarged and thoroughly revised. 12mo, 713 pages, with 341 illustrations and three colored plates. Philadelphia and New York: Lea & Febiger, 1910. (Cloth, $2.75, net.)

The rapid passage of Professor King's Manual of Obstetrics to an eleventh edition, stamps the volume as possessing in high degree the essentials required in a work of this kind.

The original aim of the author has in this revision been judiciously maintained. Brevity and lucidity of statement mark its pages without sacrifice of completeness, and as a text-book for the elementary student or work of reference for the over busy practitioner, it will continue to enjoy its well merited reputation.

Among the more important additions may be mentioned the subjects of pubiotomy, spontaneous version by posture and the factor of high-pressure upon the abdomen considered as one of the auxiliary forces of labor. The section on hyperemesis has been rewritten and the illustrations have been increased by the addition of thirty-seven new figures.

The American Journal of Physiologic Therapeutics.—Recognizing the rapid increase in interest in non-medicinal therapy Dr. H. R. Harrower, of Chicago (72 Madison street), has heard the call for a journal devoted solely to therapy along other than medicinal lines and has responded to it. This journal, which appears under the title used as our heading, is consistent from cover to cover; while in no sense antagonistic to drug medication it considers that phase of our work out of its province. It is scientific, practical, interesting, and must prove a valuable aid to those physicians who will avail themselves of its assistance. Dr. Harrower tells us that he will gladly send the journal to those of the Fortnightly readers who may request it and will read it so long as may be necessary to prove to them that they do or do not need it. You will seldom if ever find a more liberal proposition than this.

Requirements for Practice in Iowa.—Beginning in 1911 all physicians desiring to take the state medical examinations in Iowa will have to have had, in addition to their medical course, a two years' preparatory course in some accredited college. The course necessary must have included one year's work in chemistry, biology and German or French. This was decided upon at the meeting of the state board of health at Des Moines, and follows the action which has been taken in this regard by several states. All medical schools desiring to be in good standing with the Iowa board of health must have these entrance requirements, as graduates of schools who do not make necessary the two years' preparatory collegiate course will not be allowed to take the examinations for admission to practice in that state. All of the state medical schools will meet the requirements this coming year.

MEDICAL PROGRESS

Comprising the Regular Contributions of the Fortnightly Department Staff.

OTOLOGY.

A. F. KOETTER, M, D.

Two Cases of Congenital Closure of External Canal.—(H. P. Mosher, Boston Medical and Surgical Journal.)—Twins of four years sent to the hospital because of failure to advance in kindergarten. The examination reveals that the cartilaginous canal in both children is closed about one-half inch from the meatus. No history of disease, other abnormalities not present. A hearing test of any value is not to be made. X-ray in both children shows a tympanic cavity, and a shadow corresponding to the hammer. An exploratory operation is performed on one ear. First child: Incision behind auricle in the usual way, blind end of canal contains a small piece of cartilage adherent to a flat bony plate occupying about two-thirds of the space intended for the membrane, remnant of membrane not to be found. In the superior portion of the bony plate the hammer was found imbedded. To the front and inwardly a middle ear cavity lined with mucous membrane is exposed. Splitting the canal at the inner end, chiseling away the bony plate with the exception of the part corresponding head of the malleus. Incus not found. Chiseling away a part of the posterior canal wall, accidentally exposing a few large mastoid cells, a skin flap is laid into the opened cells suture. After healing the hearing is decidedly improved, and the child has become one of thebest pupils of her class.

In the other child, at the place of the bony plate, a small projection was found, probably the deformed malleus. Tympanic cavity not present so that the malleus had to be loosened artificially from a mass of connective tissue, fromation of a skin flap and suture. Suppuration made it difficult to preserve lumen of canal. On the second day post operative facial paralysis which disappeared in the course of three months. In this case the functional end result was good, the child making splendid progress.

A Case of Mastoiditis Caused by Microorganism of Angina.—(D. G. Yates, New York, Jour. A.M.A.)—Girl of 12 with neglected middle ear suppuration of several months duration. Sub-periosteal abscess behind the ear. Canal full of thick, foul pus. Operation: evacuation of abscess, larger part of corticalis was obliterated, dark, red spongy mass in mastoid process, dura of middle and inferior cranial fossa was exposed. A part of bony posterior canal wall destroyed. Small sequestrium lay in the granulation tissue. Bacteriological examination revealed the presence of microorganism of Vincent's angina (spirocheta denticola and bacillus fusiformis. Recovery uneventful, suppuration from tympanum continued yielding finally to treatment with North's lactic acid serum.

Two Cases of Involvement of the Ears Through Eye Disease.—(G. S. Ryerson, Canadian Practitioner and Review.)—Case I.—Man, 51 years of age, with myopia and choroiditis, sight poor, corresponding with an exacerbation of this trouble a buzzing sound was heard in the head, which disappeared after the eye trouble improved. This was repeated several times, without any positive findings in the ears. Case II.—Girl, 17 years of age, with myopia and choroiditis, slight nystagmus. Troublesome noises in the ears, not constant but always appearing when pain in eyes and head were noticed. Examination of ears negative, hearing normal.

Hysterical Deafness Accompanied by a Peculiar Hysterical Aphonia.—(Hans Claus, Berlin, Passow's Beitraege.)—Sudden attack with severe tinnitus, high grade of deafness, dysakusis, hoarseness, which disappeared on closure of the ears. Of the objective symptoms worthy of note are, shortening of the Schrocbach, an overlapping of the left false vocal chord through the superior thyroid-arytenoid cartilage which decreased by closure of the ears, synchronous improvement of the speech. General condition: hyperthesia of the body and the extremities, dermographia with active reflexes present. Of special mention is a sudden appearance of edema over the right arytenoid cartilage. This case should not be considered as a proof of a changeable action between the ear and voice or speech, although this could be proven experimentally. The author calls attention to the cases of respiratory spasms and attacks of coughing in hyperesthesia acustica, and to those related to the clinical picture of above, hysterical deaf mutism.

Otitis Media.—Hiram Woods, Baltimore (Jour. A.M.A., August 27), says that physicians are becoming keener in their appreciation of early ear disease and consultations regarding a possible otitic origin of systemic conditions are greatly increased. Some facts thus developed seem to him worthy of discussion. The general belief in regard to otitis media is that the ear in-

volvement is a sequel to infection elsewhere, and among these infections is influenza. To justify the diagnosis of primary otitic infection we would have to find first, systemic evidences of infection; second, objective evidence of ear disease; third, absence of local disturbances that might be a cause and, fourth, relief of constitutional symptoms and cure by treatment confined to ear drainage. If primary otitic infection is a reality and if it is capable of producing systematic infection it is our duty to insist on the necessity of including the ear in routine examinations for the cause of such symptoms. It does not always show itself in the order of exciting cause, pain and other subjective symptoms before the discharge makes diagnosis certain, and without them nothing but routine examination by a competent physician can demonstrate the cause of the general illness. Akin to primary otitic infection are the delayed ear complications of various diseases sufficiently distant in time to throw doubt on the causative relation. Such latent otities have one important bearing on every-day otology. Specialists should impress on general practitioners that they are frequent and the patient should not be dismissed as well until the ears have been examined. In this way some cases of deafness can be avoided. A feature which often puzzles not only the physician but his consultant, is the meaning of prolonged fever in extremely light cases of otitis media. Notes of three cases are given. If this fever is due to the ear it is the physician's duty to get complete drainage. If not, it is his duty to know. One may have to employ a mastoid operation, which must be avoided if the need of it does not exist, and it is sometimes a puzzling question of diagnosis. Woods lays some stress on the leucocyte count in this condition, as with it and the temperature we have pretty reliable guides regarding an otitis as a cause of systemic disturbances as distinguished from essential fevers. There is always the possibility of another lesion with the ear trouble. In deciding if mastoid drainage is needed, he thinks that the amount of the otorrhea is an important guide which is often neglected. A question which he would like to hear discussed is what is the line of demarcation between the safety of tympanic and the necessity for mastoid drainage? Is there anything outside of time and profuse discharge to guide us? He reports a case of convulsions occurring in otorrhea and relieved by incision. He has heard of other such cases. Two other cases of what he had called referred pain, in one in the neck along the sternocleido-mastoid muscle and in the other in the right parietal occipital region, were cured by treatment and incision. He thinks that they were referable to an unusual connection between the tympanic nerve and other branches of the glossopharyngeal nerve through the petorsal ganglion. In conclusion, he says that an improved attitude toward ear troubles on the part of medical practitioners has brought about a definite change in otologic practice, at least in his own. In his private work, chronic otitis media, which was formerly much seen, is rare, and even acute otitis media allowed to go on to ulceration of membrane is not very frequent, but constitutional symptoms due to ear disease without gross evidences of the latter, are more common. The moral of it all is that aurists must be good enough physicians to make differential diagnoses.

Free Esperanto Instruction.—Mr. Arthur Baker, 700 East Fortieth street, Chicago, editor of Amerika Esperantisto, writes that he has had prepared 100,000 brief grammars of Esperanto in pamphlet form, and will send one free to any person who is sufficiently interested to ask for it, inclosing a stamp for reply. The grammar has been prepared in order to give every person interested an opportunity to judge for himself regarding the probable value of this international medium of communication.

Cholera In Europe.—According to cable dispatches, September 26, several cases of cholera have been reported at Rome, 28 in Hungary with 11 deaths between September 24 and 26, and there is quite an epidemic at Naples, 100 new cases and 50 deaths being recorded during the day of the 25th. The last official reports by mail from Russia state that 154,445 cases of cholera have been reported in that country since the beginning of the epidemic last April up to August 14, with 74,723 deaths. A strolling band of gypsies from Russia started an epidemic in Apulia, the southeastern province of Italy, over a month ago, although none of the party had cholera—a typical clustration of the dangers of healthy germ carriers. The Berlin letter mentions the few cases that have occurred in Germany. A few other isolated cases have occurred since in Germany, one each at Dresden, Stade and Marienburg, and 3 germ carriers have been discovered among the Vistula River rafters. In the second week in August, 24,000 new cases were reported in Russia, with 11,000 deaths.

SOCIETY PROCEEDINGS

MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

Thirty-sixth Annual Meeting, held at Detroit, September 13-15, 1910.

The President, Dr. Frank P. Norbury, Hospital, Ill., in the chair.

Pain in Abdominal Diseases.—Dr. William M. Harsha, Chicago: In order to interpret pain properly, a careful history is necessary as pain must be considered in relation to other factors in a given case, and without these it loses its chief importance. The relation of pain to taking food is also of great value particularly in duodenal or gastric ulcer or the various stenoses, benign or malignant. The direction and extent of painful radiations and the association with hyperesthesia, local tenderness, and muscular rigidity are of great importance as indications of the site and gravity of the lesion. The arm pain in angina pectoris, the shoulder or upward radiation in gall-bladder disease and downward, forward and testicular pain in nephritic colic are well-known examples. The pain of abdominal disease may be either spontaneous or elicited by pressure, body movement or position, and it may be influenced by psychical, thermic, mechanical or chemical means, all of which may be utilized in cases to aid in exact diagnosis. Diseased viscrea cause pain at or near their various sites, but there are many exceptions which lend importance to the reflex or referred pains. A number of abdominal diseases, especially of the more acute variety, are first heralded by pain rather than by change of size, position, or other physical conditions. The surgeon can often gauge the urgency in a given case by the character and severity of pain. Taking cognizance of the value of pain associated with local distentions and peristalsis, or the absence of peristalsis, we may locate stenosis or other forms of obstruction, calling to our aid submerged palpation, or palpation in the bath, which will enable us to detect induration which is otherwise not palpable. By observing the time-relation of pain to other symptoms, the effect of food, drugs, cathartics, cold, fatigue, movement, position, jarring, fist percussion, anesthetics or electric stimulation, we should be able to increase the per cent of correct diagnoses.

The safety of abdominal section may have caused us to relax our efforts at exact diagnosis. It has frequently happened that laparotomy has been done for appendicitis when a movable kidney, pyelonephritis, ureteral stone, typhoid, diaphragmatic pleurisy, salpingitis, or some other condition is present. Age, sex, occupation, or previous history may give valuable aid. In childhood, intestinal troubles prevail, and we are likely to encounter appendicitis, intussusception, or tuberculosis, and in advanced age malignant disease. In women, the pelvic organs are frequent sites of disease, while gall-stones are frequent. Lead colic may simulate organic disease. A history of indigestion, with vague epigastric pain, may aid in determining a perforation of the duodenum or stomach, and a record of previous inflammatory trouble in the abdomen may explain a sudden intestinal obstruction. Among the less frequent conditions may be mentioned the meteorism with abdominal pain, resulting from the embarassed portal circulation in cardiac insufficiency. I have recently seen a case of this kind in which the pain was so pronounced and distentions so great that abdominal tumor was suspected by one physician. We should consider the possibility of disease of the central nervous system, such as tabes, herpes, or hysteria, disease of the spine, as caries, or spondylitis deformans. We should also consider the possibility of disease of the thorax, referring pain and rigidity to the abdomen; or to one kidney referring the pain from stone to the kidney of the opposite side. Excluding pain from the cord, spine or reflex causes, we should remember that diseased viscera may be at the normal site, displaced especially by prolapse, or transposed. On the surgeon falls the burden of responsibility for exact diagnosis, as his operative experience should add to his knowledge.

DISCUSSION.

Dr. William Fuller, Chicago: The man who can best interpret the significance of pain is the one who has suffered some pain. While I do not think it necessary to have all the acute abdominal diseases in which there is great pain to make a diagnosis, I think a little knowledge gained in a practical way helps out very much. Dr. Harsha's paper contains two excellent points: First, is the emphasis that he lays on the fact that abdominal pains may be severed from trivial abdominal affections; second, is his statement that very serious abdominal affections may be unattended by pain.

Dr. Channing W. Barrett, Chicago: When a patient complains of pain generally over the abdomen from appendicitis or gall-bladder trouble, we find frequently by putting the finger on the point that is affected, or

supposed to be affected, and making a little pressure that the surrounding pain disappears. We can then go over the rest of the abdomen, and while the patient may complain of local pain, the rest of the pain is gone. An anesthetic is of great value sometimes in pelvic and abdominal cases, but I think we gain more knowledge of these conditions by examining the patient first without anesthetic.

Dr. L. W. Bremerman, Chicago: In diseases of the kidney or the ureter, I have seen cases in which there was hematuria, with marked pain over the region of the kidney, the kidney being felt on palpation, excessive tenderness over the kidney, a kidney lesion diagnosed, and surgical intervention recommended. On cystoscopic examination of the individual, discovered that the hematuria was developing from the supposed healthy kidney, the urine from the supposedly diseased kidney being normal. Every method of examination should be resorted to before an absolute diagnosis is made.

[To be continued.]

MEDICAL MISCELLANY

A law just enacted in Sweden prohibits the erection of a dwelling house more than five stories in height. The elevation of the building must not exceed the width of the street by more than five feet.

Dr. Scott P. Child, Jesse E. Hunt, Otho L. McKillip, Archie N. Johnson, Eugene P. Hamilton, Frank C. Neff, Fred B. Kysger, W. H. Bailey, F. LaMar, and William J. Thompkins have been appointed medical inspectors of the public schools of Kansas City.

In Chicago, at the close of the first eight months of the current year, 22,808 deaths had been reported to the department of health, 4,133 of which were due to pneumonia, 2,745 to tuberculosis, and 2,265 to gastro-intestinal diseases of children. The three named diseases caused 40 per cent of the total number of deaths.

Colored Practitioners Hold Meeting.—Colored physicians, dentists and pharmacists, making up the National Medical Association, held their meeting in Washington, D.C., August 23 to 25. Hampton Institute, Hampton, Va., was named for the next meeting-place and the following officers were elected: President, Dr. Austin M. Curtis, Washington, D. C.,; vice-presidents, Drs. William M. Slowe, Philadelphia, and Dr. L. H. Singleton, Washington, D. C.; general secretary, Dr. J. A. Kenny of the Tuskegee Institute, Ala., and member of the executive board, Dr. John W. Jonese, Winston Salem, N.C.

Plague in Hawaii.—The last case of human plague at Honolulu occurred on July 12, 1910, and the last plague infected rat was found at Aiea, nine miles from Honolulu, on April 12th. At Hilo the last case of human plague occurred on March 23d, and the last plague infected rat was found in Piihuona, four miles from Hilo, on April 9th. Passed Assistant Surgeon Ramus reports that during the week ending August 27th the total number of rats and mongoose taken was 780, and the average number of traps set daily was 1,738. Ten medical officers of the Public Health and Marine Hospital Service are conducting the national quarantine, and are waiting the territorial health board in preventing the recurrence of plague by the extermination of rats and the continuous bacteriological examination of those captured. During the last fiscal year 25,000 rats were examined in the laboratory, only one rat being found infected with plague.

The Effects of Rapid and Prolonged Deep Breathing are described in "Science" (Dec. 31, 1909) by D. F. Comstock, of the Massachusetts Institute of Technology. They are sufficiently startling to warrant more attention from physicians, for he truly states that though they are well known in a general way, scientists as a rule are ignorant of the matter and there are many occasions in which the process can be put to valuable uses. Briefly it may be explained that the blood is thus so supersaturated with oxygen, that all the functions are stimulated to greater activity and respiration can be suspended for three to five minutes. Consequently, there is a rise in the pulse-rate, mental fatigue is lessened, sleepiness disappears and muscular power is greatly increased as in the case of oxygen inhalations of athletes. These results follow deep respirations of less than four minutes. Pearl divers practice the method and stay under the water five minutes or longer, but as they are notoriously short-lived, we must warn against the dangers lest the method might be adopted by swimmers to their ultimate ruin. It is the ordinary method of respiration of whales, but they have evolved lungs which are not strained by one very deep inspiration which supplies enough oxygen for many minutes. Yet it is a good thing for swimmers and firemen to know, when rescue work demands a cessation of respiration for some minutes even at some risk.—American Medicine.

THE MEDICAL FORTNIGHTLY

A Cosmopolitan Biweekly for the General Practitioner

The Medical Fortnightly is devoted to the progress of the Practice and Science of Medicine and Surgery. Its aim is to present topics of interest and importance to physicians, and to this end, in addition to a well-selected corps of Department Editors, it has secured correspondents in the leading medical centers of Europe and America. Contributions of a scentific nature, and original in character, solicited. News of Societies, and of interesting medical topics, cordially invited.

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FAVORITE PRESCRIPTIONS

Insomnia (of nervous origin, without pain).—

Veronal.....grn. v
Mitte xii.

Sig.: One to two powder at night, to be taken dissolved in a hot liquid—hot tea or hot water.

Linseed Emulsion.—

Linseed oil.....15 ozs.
Wintergreen oil.....2 drs.
Cinnamon oil.....2 drs.
Hydrocyanic acid, dil.....2¼ drs.
Glycerin.....5 drs.
Syrup.....10 ozs.
Irish moss.....¼ oz.

Make an emulsion in the proper manner (by macerating the Irish moss in hot water, etc.). The linseed oil must, of course, be of the highest quality obtainable. The above is the formula for the simple emulsion, the dose of which is two to four teaspoons three times a day or oftener. It may be enforced by adding small quantities of chloral hydrate, codein, dionin or heroin.—Med. Council.

Protective Dressing.—An excellent firm dressing for varicose veins, ulcers, etc., is made as follows:

℞ Glycerine.....1 part
Zinc oxide.....1 part
Gelatine (white).....1 part
Water.....3 parts

M. Heat in water bath. Sig.: Apply several coats with brush.

Treatment of Tapeworm.—Dr. J. C. Patterson treats tapeworm as follows: The first day the patient is fed only on bread and milk and meat-broth, and given six doses, ¼ to ½ grain each, of calomel, followed by a bottle of magnesium citrate, given in four doses, one half hour apart. The following morning he administers the teniacide:

℞ Oleoresin male-fern.....3ij
Chloroform.....3ij
Glycerin.....3ij-iv

This is followed in an hour or two by an ounce of castor oil. With this method of treatment, Dr .Patterson has been perfectly successful in a considerable number of cases.—Medical Times.

Ointment for Lumbago.—

℞ Acid salicylic.....3j
Camphor.....3ij
Chloral.....3ij
Oleoresin capsici.....gtt. xx
Ol. sinapis.....gtt. xv
Petrolati.....ad. 3ij

M. Sig.: Apply with strong friction three times a day.—Critic and Guide.

It has been shown under the microscope that streptococcus erysipelas destroys cancer cells.

Two transatlantic steamships, one of them the Cunard liner Lusitania, were held up by the New York health authorities, September 1, because of the cholera scare abroad. The Lusitania arrived after nightfall, and left quarantine at 8:30 only to be stopped off Stapleton, Staten Island, for further inspection. A steerage passenger had been found seriously ill by inspectors, and while there was nothing to indicate cholera it was decided to hold the vessel and take no chances pending a bacteriological investigation, which later proved negative.